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Employer Best Practice Guidelines for the Return to Work of Workers on Mental Disorder–Related Disability Leave: A Systematic Review

Lignes directrices des pratiques exemplaires des employeurs pour le retour au travail des travailleurs en congé d'invalidité lié à un trouble mental : une revue systématique

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Abstract

Objective: There has been an increasing number of employer best practice guidelines (BPGs) for the return to work (RTW) from mental disorder–related disability leave. This systematic review addresses 2 questions: 1) What is the quality of the development and recommendations of these BPGs? and 2) What are the areas of agreement and discrepancy among the identified guidelines related to the RTW from mental illness–related disability leave?

Method: A systematic literature search was performed using publically available grey literature and best practice portals. It focused on the RTW of workers with medically certified disability leave related to mental disorders. The Appraisal of Guidelines for Research and Evaluation II (AGREE II) was used to assess the quality of the development and recommendations of these BPGs.

Results: A total of 58 unique documents were identified for screening. After screening, 5 BPGs were appraised using AGREE II; 3 BPGs were included in the final set. There were no discrepancies among the 3, although they were from different countries. They all agreed there should be: 1) well-described organizational policies and procedures for the roles and responsibilities of all stakeholders, 2) a disability leave plan, and 3) work accommodations. In addition, one guideline suggested supervisor training and mental health literacy training for all staff.

Conclusion: Although there were no discrepancies among the 3 BPGs, they emphasized different aspects of RTW and could be considered to be complementary. Together, they provide important guidance for those seeking to understand employer best practices for mental illness–related disability.

Résumé

Objectif : Il y a un nombre croissant de lignes directrices des pratiques exemplaires des employeurs (LDPE) pour le retour au travail (RAT) après un congé d'invalidité lié à un trouble mental. Cette revue systématique pose deux questions: (1) Quelles est la qualité de l'élaboration et des recommandations de ces LDPE? et (2) Quels sont les domaines d'entente et de divergence parmi les lignes directrices identifiées liées au RAT après un congé d'invalidité lié à un trouble mental?

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Méthode : Une recherche systématique de la littérature a été menée à l'aide de la littérature grise offerte au public et des portails des pratiques exemplaires. Elle portait sur le RAT des travailleurs ayant eu un congé d'invalidité lié aux troubles mentaux médicalement certifié. L'Évaluation critique de guides de pratique clinique (AGREE II) a servi à évaluer la qualité de l'élaboration et des recommandations de ces LDPE.

Résultats : Un total de 58 documents uniques ont été repérés pour la sélection. Après la sélection, cinq LDPE ont été évaluées à l'aide d'AGREE II; trois LDPE ont été incluses dans l'ensemble final. Il n'y avait pas de divergences parmi ces trois malgré qu'elles proviennent de différents pays. Elles étaient unanimes sur le fait qu'il devrait y avoir: (1) des politiques et procédures bien définies sur les rôles et responsabilités de tous les intervenants; (2) un plan de congé d'invalidité; (3) des mesures d'adaptation au travail. En outre, une des trois lignes directrices suggérait une formation pour les superviseurs et une formation en connaissance de la santé mentale pour tout le personnel.

Conclusion : Bien qu'il n'y ait pas eu de divergences entre les trois LDPE, elles mettaient en évidence différents aspects du RAT et peuvent être considérées complémentaires. Ensemble, elles offrent une orientation importante à ceux qui cherchent à comprendre les pratiques exemplaires des employeurs pour l'invalidité liée à la maladie mentale.

Keywords
best practices, mental disorders, return to work, work disability

The burden of mental disorders among the labour force has been estimated to cost Can$51 billion annually.[1] A significant proportion of these costs is associated with work disability, which takes the forms of absenteeism and presenteeism.[2] This means that a large proportion of these costs is borne by workers and their workplaces.[3] Mental illness–related short-term disability (SDIS) episodes are among the most costly types of absenteeism.[3] This is because of their length and risk of recurrence.[2-4] This suggests that there are a number of ways in which costs could be prevented. In addition to preventing mental illness–related SDIS episodes, costs could be addressed by decreasing the length of the episodes and their recurrence.

Although they are health related, SDIS benefits are sponsored by employers. They are designed to replace a worker's lost income when she or he experiences a disability that requires an absence from work. In addition to income replacement, SDIS benefits include disability case management and return to work (RTW) programs. Over the past decade, there has been a precipitous increase in the number of studies examining new mental illness–related RTW interventions as well as systematic reviews covering the topic.[5,6] In turn, there have been an increasing number of best practice guidelines (BPGs) for employers. For employers seeking to provide employees with quality RTW programs, this can be confusing. Which guideline should be followed? Are guidelines consistent in their recommendations? As physicians assist their patients in returning to work, which guidelines could they suggest for workplaces to follow?

The purpose of this systematic review is to identify BPGs for mental illness–related disability practices for employers in the grey literature. We use the US Institute of Medicine's (IOM's) definition of BPGs,[7(p4)] such that they are "statements that include recommendations intended to optimize patient care that are informed by a systematic review of the evidence and an assessment of the benefits and harms of alternative care options." Grey literature is defined as documents produced by government, academics, business, or industry but not controlled by commercial publishers.[8] The grey literature serves as a valuable barometer of public interest, reflective of current priorities and future ones.[9] Policy context and implications such as those communicated in BPGs may be located only in the grey literature.[9] Thus, searching for grey literature documents retrieves documents that would not be identified elsewhere.[10] Furthermore, the target audience for the employer BPG would not necessarily be expected to search the academic literature.

Using the Appraisal of Guidelines for Research and Evaluation II (AGREE II),[11] we answer the following questions: 1) What is the quality of the development and recommendations of these BPGs? and 2) What are the areas of agreement and discrepancy among the identified guidelines related to the RTW of workers who are on mental illness–related disability leave?

Background

BPGs are considered useful tools to summarize and translate scientific evidence into recommendations that can be used in practice.[12,13] Because guidelines are based on the best available scientific evidence that is supplemented by professional and patient expertise and tailored to the local context, they can differ by country or jurisdiction.[14] Studies have shown that the quality of the development of guidelines also can vary considerably.[15-17] Because it can be difficult to discern the cause of the variation, there is a need for quality and transparency in describing how guidelines are developed. In this way, it is possible to distinguish between variations related to context versus variations due to the evidence used to develop them.[7,18]

The IOM's[7] BPG definition identifies 3 necessary criteria: 1) the document offers recommendations for optimal behavior, 2) the recommendations should be based on a systematic review of the evidence, and 3) an assessment of the benefits and harms of the recommendations should be offered. Based on a systematic review of the evidence, BPGs are distinct from consensus statements, expert advice, and standards. The criterion that recommendations be based on a systematic review of

the evidence distinguishes BPGs from other types of recommendations and standards. The review of the evidence involves an evaluation of the strength of the evidence, which ranges from randomized controlled trials (RCTs) to expert opinion.[7]

By describing the strength of the evidence associated with the recommendations, BPGs become more transparent. To promote transparency, the IOM[7(p18)] also developed standards to determine whether BPGs are trustworthy and of quality. Trustworthy and high-quality BPGs should have the following attributes: 1) validity, 2) reliability/reproducibility, 3) applicability, 4) flexibility, 5) clarity, 6) a multidisciplinary development process, 7) scheduled review/update, and 8) documentation. In its report, the IOM[7] included the AGREE II as an example of an appraisal instrument that reflects these attributes.

As the evidence has accumulated for the management of mental health problems in workers, so has the proliferation of BPGs. For example, a recent review found that evidence-based guidelines for health care professionals to improve the management of mental health problems in workers have been developed in a number of countries.[7] Joosen et al.[19] found that although the guidelines' recommendations are comparable, not all available guidelines meet the IOM standards for development and reporting quality.

Given that clinicians are only one partner in the collaborative effort in the RTW process, an understanding of the best practices for employers is also important. Indeed, it may be helpful to be able to have evidence-based recommendations to which clinicians could direct workplaces.

Methods

This systematic literature review used publically available grey literature and best practice portals. It neither involved the collection nor the use of primary data. As such, it was not subject to research ethics board review. We used the items from the AMSTAR[20] to guide the reporting of this study.

A grey literature search strategy was developed in collaboration with a professional science librarian. The search strategy was based on methods detailed by Lopez et al.[21] Structured searches using Google Advance Search were conducted individually for the 6 English-speaking countries: Canada, United States, England, Ireland, Australia, and New Zealand. Each search was restricted by the geographic region of interest and limited to English-language PDF/Word documents. Review was focused on the first 50 search results.[21] Only unique references were counted in each search.

The searches were completed between February 2014 and October 2014. The following key words were used:

1. best + practices + mental health OR mental disorder + workplace
2. best + practices + mental health OR mental disorder + employers + work

The primary searches were conducted using the Google search engine. Source websites of relevant documents identified in the primary searches were searched for further documents of interest. Best practice portals identified through Google searches and the literature were also used to search for best practice documents as were websites developed and maintained by organizations that were identified as being relevant to the subject, including the National Guideline Clearinghouse, US Centers for Disease Control and Prevention, Guidelines International Network, Public Health Agency of Canada Canadian Best Practices Portal, and Canadian Centre for Occupational Health and Safety.

Best practice portals also contain guidelines from the published literature. For example, the National Guideline Clearinghouse is maintained by the US Agency for Healthcare Research and Quality, and the Clearinghouse functions as a guideline database. Methods for identifying current and relevant guidelines for consideration include weekly iterative searches of the literature using databases that include PsycInfo, PubMed, CINAHL, and Embase. Thus, although we did not explicitly search electronic databases such as Medline or PsycInfo, our search of the best practice portals would have been an indirect search of relevant BPGs from these electronic databases.

Eligibility Criteria

The grey literature review focused on BPGs relevant to RTW from an SDIS leave and targeted for employers. The search focused on identifying RTW BPGs for working adults who had a mental illness–related SDIS. Documents were excluded from the search if they consisted of job postings, advertisements, consulting brochures, documents that were specific to youth/children, or PowerPoint slides without references.

Documents were screened in 3 phases by 2 reviewers. The following inclusion criteria were used:

1. The document included recommendations related to RTW after an SDIS leave related to a mental disorder.
2. The BPGs were specifically targeted for use by employers.
3. The BPGs were based on a systematic review of the evidence.

In the first and second phases, each document was assessed for the first 2 criteria. In phase 1, the assessment was based on document title. In phase 2, documents that passed the first phase were evaluated based on a full-text review. The interrater reliability corrected for chance agreement was 0.94. Documents for which there were rater disagreements were discussed until consensus was reached.

Quality Assessment

Documents that passed the second screening phase went through a third screen in which they were evaluated using the AGREE II tool.[22] AGREE II was developed to assess the quality and reporting of guideline recommendations. AGREE II includes 23 items divided among 6 domains, in

addition to an overall assessment score and is based on the IOM's[7] standards to determine whether BPGs are trustworthy and of quality. Each item is a statement illustrating 1 of the standards and is scored on a scale of 1 (*strongly disagree* or no information was provided for this item) to 7 (*strongly agree*), such that higher scores are indicative of higher quality. The 6 domains were the following:

Domain 1 (3 items): Scope and purpose
Domain 2 (3 items): Stakeholder involvement
Domain 3 (8 items): Rigor of development
Domain 4 (3 items): Clarity of presentation
Domain 5 (4 items): Applicability
Domain 6 (2 items): Editorial independence

Domain scores were calculated using the formula

$$\text{Domain score} = \frac{(\text{total item scores} - \text{minimum possible score})}{(\text{maximum possible score} - \text{minimum possible score})} \times 100$$

The AGREE II Domain 3 score and the overall assessment score were used to determine whether inclusion criterion (3) was met. The AGREE II manual[11] suggests that evaluators determine a cutoff for the domain and overall scores. We adopted the Canadian academic evaluation cutoffs, which require scores of >50% to pass. Domain 3 focuses primarily on the evidence used to develop the guideline. Thus, we operationalized inclusion criterion (3) as a score of >50% on Domain 3 and an overall AGREE II score of >50%.

Analysis

Included documents were analyzed using a content analysis approach. Documents were read independently by 2 raters. Each rater independently identified and summarized key recommendations. Raters then compared and discussed their summaries for agreement and discrepancy. Any disagreements were discussed until consensus was reached.

Results

Description of Inclusion and Exclusion

The title review resulted in the identification of 58 unique documents. Figure 1 is a PRISMA flow diagram.[23] It illustrates the steps of the systematic review by showing the number of records identified, included, and excluded and the reasons for exclusions at each step. After the full-text review, 5 documents were included for the quality assessment. Documents were excluded because because they 1) did not contain relevant recommendations ($n = 36$), 2) were not focused on RTW from mental illness–related SDIS ($n = 1$), and 3) were not based on a systematic review of the literature ($n = 16$). (The list of the excluded documents is available upon request from the first author.)

Quality Assessment

Upon quality assessment, 2 of the 5 BPGs received Domain 3 scores of ≤50% and overall scores of ≤50%. Low scores in Domain 3 were the result of a lack of details about the systematic methods used to search for evidence, criteria used to select the evidence, discussion of the strengths and limitations of the evidence that was used, and the link between the recommendations and the supporting evidence and procedures for updating the BPGs (Table 1).

The BPGs also had low scores in Domain 5: Applicability. There was limited discussion about recommendations for implementing the guidelines, potential resource implications of their application, and monitoring and (or) auditing criteria.

Figure 2 is a risk-of-bias graph.[24] It shows the domain scores and the percentage of BPGs for which they apply. The highest scores were in Domain 1: Scope and Purpose (80%-100%) and in Domain 4: Clarity of Presentation (70%-89%). The lowest scores were in Domain 5: Applicability (0%) and Domain 6: Editorial Independence (0%).

The low scores were related to the absence of information. For example, only 1 guideline discussed the influence of the funding body or competing interests of group members. In addition, although relevant literature could have been used in the development of the guidelines, most were not transparent about how the evidence was searched for, selected, or linked to recommendations. Only 1 guideline described a future for further update. None of the guidelines offered information about how the evidence could be applied in practice.

Best Practice Recommendations

The 3 included guidelines were from Canada, the United Kingdom, and Australia.[25-27] The guidelines from Canada and Australia begin by recommending the implementation of a well-defined disability policy (Table 2). This policy should describe the roles and responsibilities of the worker, manager, and organization. In addition, the procedures that are to be followed should be well described. The Canadian guidelines emphasize that the policy be clear.

All of the guidelines suggest that there be a plan for the disability leave. This includes a plan for regular communication between the organization and the employee. All the guidelines agree that RTW should be coordinated and planned. Although the UK guidelines suggest that this is an option, the Canadian and Australian ones assert that this should be the default. In addition, the RTW plan should be facilitated by a designated coordinator who supports the communication among the supervisor, the worker, and the organization. Furthermore, the guidelines from the United Kingdom and Canada recommend that intensive, multidisciplinary, evidence-based interventions be offered. In the

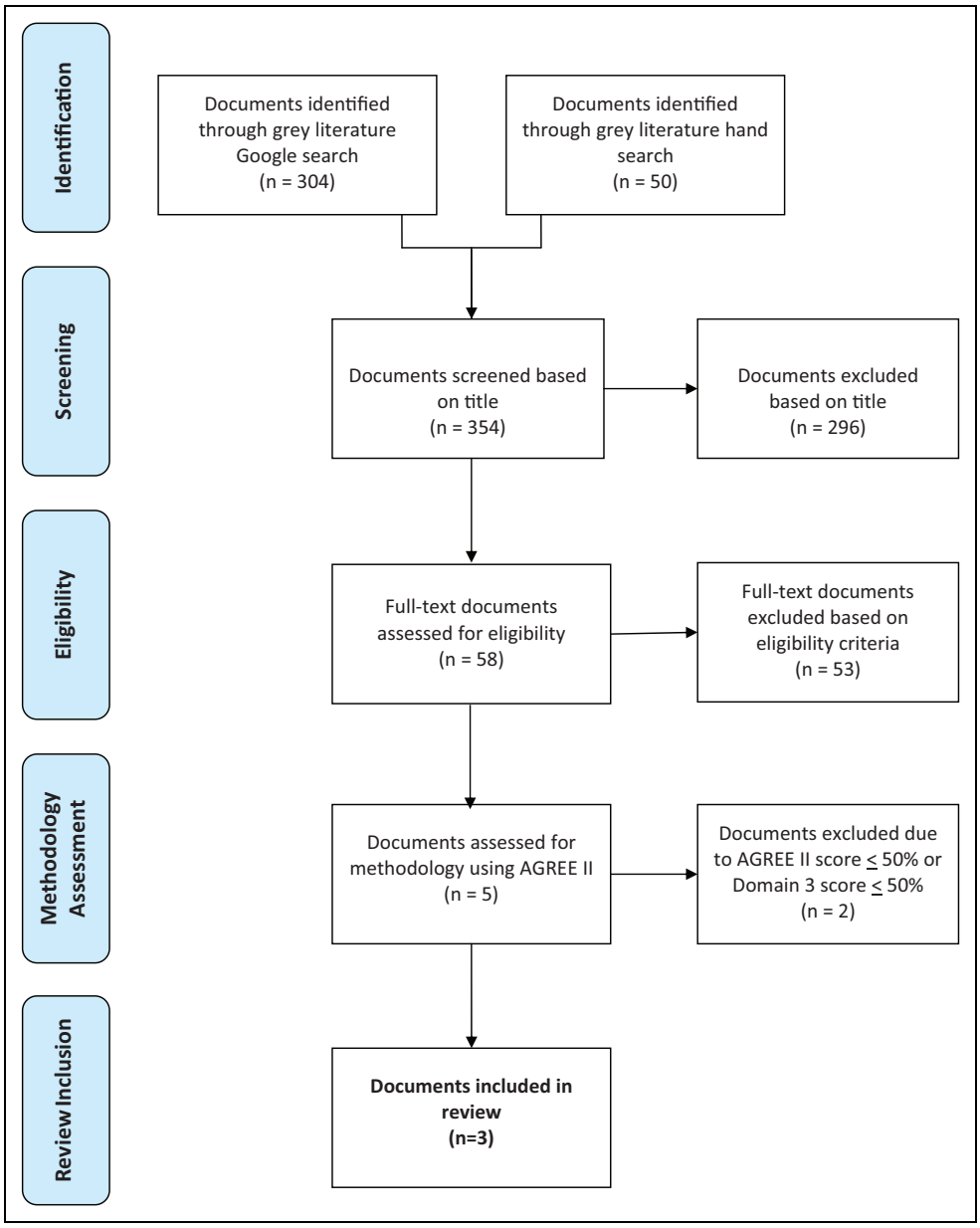

Figure 1. Flowchart of search results and inclusions/exclusions.

Australian and Canadian guidelines, there is also an emphasis on supporting workers to obtain available treatments.

Although all refer to the need for a supportive RTW environment, the Australian guidelines take the additional step of recommending supervisor training as well as providing mental health literacy training to all staff. All the guidelines concur that work accommodation should be offered. The UK guidelines suggest offering an option of a work assessment conducted by the worker and the line manager.

Discussion

Our systematic review identified 5 English-language BPGs for mental illness–related disability practices for employers. Based on the AGREE II criteria, 2 of the 5 BPGs did not include sufficient information to determine the rigor of their development and their implementation applicability. The remaining 3 received overall scores of 67% to 83%.

The AGREE II assessment results indicate there are variations in the development and recommendation quality of the guidelines included in this study. Our findings are consistent with the results of quality appraisals of other occupational BPGs. As with other studies, we found that the purpose and aims are well described; the common flaws were related to lack of information about editorial independence, the development process, and implementation.[16,17,19,28-30]

The weakest point of the guidelines is related to the implementation applicability (Domain 5). This is an

Table 1. Appraisal of Guidelines for Research and Evaluation (AGREE) domain scores for reviewed documents.*

Document name	Author	Funder(s)	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6	Overall score
Canada									
Best Practices for Return-to-Work/ Stay-at-Work Interventions for Workers with Mental Health Conditions	Occupational Health and Safety Agency for Healthcare in BC	Occupational Health and Safety Agency for Healthcare in BC	94.4%	55.6%	34.4%	75.0%	0.0%	0.0%	66.7%
Depression & Work Function: Bridging the Gap between Mental Health Care & the Workplace	The Depression in the Workplace Collaborative	Healthcare Benefit Trust, The Great West-Life Assurance Company, Mental Health Evaluation and Community Consultation Unit at the University of British Columbia	58.3%	52.8%	0.0%	72.2%	0.0%	0.0%	41.7%
United Kingdom									
Best Practice in Rehabilitating Employees following Absence due to Work-Related Stress	Institute for Employment Studies	Health and Safety Executive	75.0%	44.4%	16.7%	27.8%	14.6%	50.0%	33.3%
Managing Long-term Sickness and Incapacity for Work	NICE	NICE	97.2%	77.8%	79.2%	80.6%	39.6%	0.0%	83.3%

(continued)

Table 1. (continued)

Document name	Author	Funder(s)	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6	Overall score
Australia									
Helping Employees Successfully Return to Work following Depression, Anxiety or a Related Mental Health Problem. Guidelines for Organisations	Centre for Youth Mental Health, University of Melbourne	beyondblue, NHMRC Australia Fellowship	88.9%	77.8%	36.5%	55.6%	22.9%	0.0%	66.7%

[a] Each item within a domain had a minimum score of 1 and a maximum score of 7. Two raters scored each item independently. The maximum sum for a domain was the number of items × 2 (the number of raters) × 7 (the maximum score for an item). The domain score was calculated by summing all the scores in a domain and scaling the total as a percentage of the highest possible score for that domain. For each domain, the scores of all of the items assigned by both raters were summed. The scaled domain score was calculated as: [(obtained score – minimum possible score)/(maximum possible score – minimum possible score)] × 100. Document ratings used the AGREE II instrument. The purpose of these ratings was to assess guideline quality (1 = *strongly disagree*, 7 = *strongly agree*). Instrument items and domains are as follows:

Domain 1: Scope and Purpose.
1. The overall objective(s) of the guideline is (are) specifically described.
2. The health question(s) covered by the guideline is (are) specifically described.
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

Domain 2: Stakeholder Involvement
4. Guideline development group includes individuals from all relevant professional groups.
5. View and preferences of the target population have been sought.
6. The target users of the guidelines are clearly defined.

Domain 3: Rigour of Development
7. Systematic methods were used to search for evidence.
8. The criteria for selecting the evidence are clearly described.
9. The strengths and limitations of the body of evidence are clearly described.
10. The methods for formulating the recommendations are clearly described.
11. Health benefits, side effects, and risks were considered in formulating the recommendations.
12. There is an explicit link between the recommendations and the supporting evidence.
13. The guideline has been externally reviewed by experts prior to its publication.
14. A procedure for updating the guideline is provided.

Domain 4: Clarity of Presentation
15. The recommendations are specific and unambiguous.
16. The different options for management of the condition or health issue are clearly presented.
17. Key recommendations are easily identifiable.

Domain 5: Applicability
18. The guideline describes facilitators and barriers to its application.
19. The guideline provides advice and/or tools on how the recommendations can be put into practice.
20. The potential resource implications of applying the recommendations have been considered.
21. The guideline presents monitoring and/or auditing criteria.

Domain 6: Editorial Independence
22. The views of the funding body have not influenced the content of the guideline.
23. Competing interests of guideline development group members have been recorded or addressed.
Overall guideline assessment

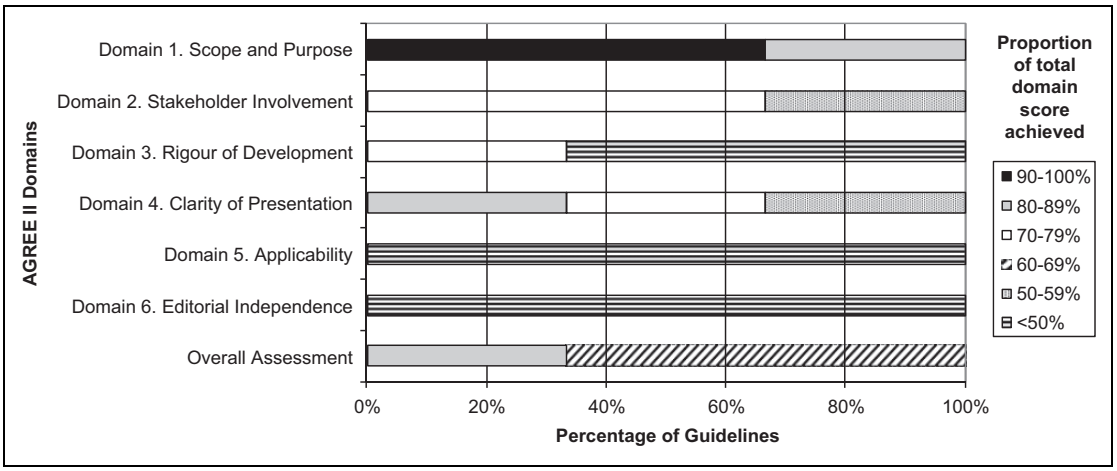

Figure 2. Summary of Appraisal of Guidelines for Research and Evaluation II (AGREE II) domain scores.

Table 2. Summary of best practice guideline recommendations.

	Canada	United Kingdom	Australia
	Best Practices for Return-to-Work/ Stay-at-Work Interventions for Workers with Mental Health Conditions	Managing Long-term Sickness and Incapacity for Work	Helping Employees Successfully Return to Work following Depression, Anxiety or a Related Mental Health Problem. Guidelines for Organisations
Return-to-work coordinated and planned	X	X	X
Work accommodation	X	X	X
Access to mental health treatment	X	X	X
Leave that is coordinated		X	X
Assessment of disability		X	X

important domain because even guidelines that follow all of the IOM recommendations[7] do not lead to quality practices if they are not adopted and used. Domain 5 potentially addresses this problem by considering the usability of the guidelines. Several studies have reported that although guideline-driven care can be effective in promoting the quality of occupational health care, clinicians' compliance with the guidelines is less than optimal.[31,32] This is the case with guidelines in general; it is difficult to achieve clinician adherence.[33-35] However, the development and reporting of recommendations are an important step toward their successful implementation.[30] In addition, because there have been few studies examining the effectiveness of the guideline implementation process, this is a subject that requires further investigation.

There were no discrepancies among the 3 guidelines from Canada, the United Kingdom, and Australia. Part of this could be attributed to the fact that they were all released within a similar time period. The Canadian guidelines were published in 2009, the UK guidelines in 2010, and the Australian guidelines in 2011. Because they all were based on the same pool of available evidence, they offered similar recommendations.

However, there were differences in emphasis. Thus, they are complementary and provide details in different areas. Because of this, an employer interested in best practices for mental illness–related disability practices could get a more complete picture by consulting all 3 rather than focusing only on 1.

For example, both the Australian and Canadian guidelines support the development of clear organizational policies and procedures. With this, they seek to promote equity in treatment of workers both going on to SDIS related to mental disorders and returning from it. This may be due to the vulnerability that these workers may face because of mental illness–related stigma.[36]

The guidelines also recommend a coordinated RTW plan that includes work accommodation. All the guidelines recognize there are a variety of stakeholders and suggest they should be involved in the RTW process. All refer to the need for a supportive work environment. Based on the recommendations, coordination and planning could involve the worker, manager, and an RTW coordinator. Work accommodations could be developed through the worker and line manager working together. All the guidelines also recognize a role for treatment for mental disorders and the need for workplaces to support access to them. In addition to treatments, the guidelines also highlight the potential effectiveness of work-focused interventions.

The guideline recommendations included in this study share similarities with guidelines for clinicians.[19] The 2 sets of guidelines agree on providing access to mental health treatment, arranging work accommodations, and the importance of communication among the stakeholders. The differences between the 2 sets of guidelines are that employer actions also should include developing clear RTW policies and coordinating guidelines as well as planning the RTW. In contrast, the clinician focus is on assessing mental health symptoms, inventorying problems with functioning, and providing counseling techniques that facilitate RTW.

Since 2011, the last publication year of the most recent included guideline, a Cochrane systematic review has been published that evaluates the strength of the evidence for RTW interventions for workers with depression.[37] One of the findings indicates there is evidence that interventions including workplace changes (e.g., work modification and job coaching) in addition to clinical treatment have a greater impact on sickness absence than clinical interventions alone. Thus, the review supports the existing guideline recommendations for the collaboration among stakeholders.

Limitations of the Guidelines

One of the limitations of the guidelines is that they do not incorporate the latest evidence. Since guidelines depend on scientific evidence, and this evidence changes over time, it was surprising that only 1 guideline provided a procedure for updating.

Limitations of the Search Strategy

The search was limited to English-language documents. Thus, we did not include guidelines from other non–English-speaking countries. In addition, if the documents were not identified either through the searches or in best practice databases, they would have been missed.

Conclusions

We identified 3 BPGs related to the RTW of workers who are on mental illness–related disability leave that met our inclusion criteria. There were no discrepancies among the 3 guidelines from Canada, the United Kingdom, and Australia. However, each emphasized different aspects of RTW. Thus, together they provide important guidance for employer best practices for mental illness–related disability leaves.

Clinical Implications

- As physicians assist their patients in returning to work, being able to recommend high-quality guidelines to workplaces may assist their patients in their return.
- As well as an RTW plan, the guidelines recommend a coordinated and planned disability leave.

Limitations of the Study

- The search was limited to English-language documents.
- Because the Canadian guidelines were published in 2009, the UK guidelines in 2010, and the Australian guidelines in 2011, they do not necessarily represent the most recent evidence.

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